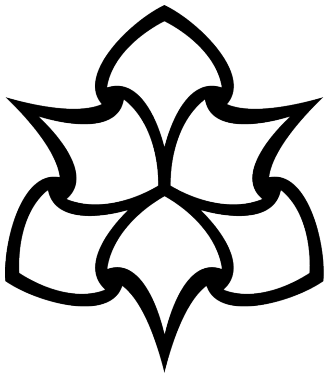

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How do managerial techniques evolve over time? The distortion of "facilitation" in healthcare service improvement

Roman Kislov [a], John Humphreys [b] and Gill Harvey [c]

[a]Alliance Manchester Business School, The University of Manchester, Manchester, UK; [b]NIHR CLAHRC Greater Manchester, Salford Royal NHS Foundation Trust, Salford, UK; [c]School of Nursing, The University of Adelaide, Adelaide, Australia

ABSTRACT

When applied to solving real-world problems in the public sector, managerial techniques are likely to evolve over time in response to the context of their implementation. The temporal dynamics of this evolution and its underlying processes, however, remain under-researched. To address this gap, we present a qualitative longitudinal case study of a UK-based knowledge mobilization programme utilizing "facilitation" as a service improvement approach. We describe the processes underpinning the distortion of facilitation over time and argue that an uncritical and uncontrolled adaptation of managerial techniques may mask the unsustainable nature of the resulting improvement outcomes captured by conventional performance measurement.

KEYWORDS Facilitation; service improvement; context; distortion; healthcare

Introduction

How do managerial techniques evolve over time? To address this question, we focus on the temporal dynamics and mechanisms involved in the evolution of *facilitation*, a service improvement approach that can be broadly defined as enabling the processes of learning in group contexts (Gregory and Romm 2001) and is often deployed to mobilize (research) knowledge into (professional) practice (Berta et al. 2015; Harvey et al. 2002).[1] Drawing on a qualitative longitudinal case study of a UK-based healthcare knowledge mobilization programme, we describe the following three parallel and overlapping practice-level processes, underpinning the evolution of facilitation over time: (1) prioritization of (measurable) outcomes over the (interactive) process, (2) reduction of (multi-professional) team engagement and (3) erosion of the facilitator role.

We argue that an uncritical and uncontrolled adaptation of managerial techniques may lead to their gradual *distortion*, undermining their promise to positively affect organizational learning processes and masking the unsustainable nature of the resulting improvement outcomes captured by conventional performance measurement (Downe et al. 2010). Our analysis highlights the malleability of the "core"

CONTACT Roman Kislov roman.kislov@manchester.ac.uk
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components of managerial techniques under the influence of powerful institutional forces. In doing so, it responds to the call to explore the interrelationship between the host organizations of managerial innovation and their environment (Osborne and Brown 2005) and reveals potential unintended consequences stemming from the adaptation of managerial techniques to local contexts advocated by the innovation and implementation literature (Fervers et al. 2006; Kirsh, Lawrence, and Aron 2008; Krein et al. 2010; Mariano and Casey 2015).

Our findings are likely to be applicable to a wide range of learning-oriented managerial techniques, such as the "learning organization" (Ferguson-Amores, García-Rodríguez, and Ruiz-Navarro 2005; Thomas and Allen 2006) and "communities of practice" (Bate and Robert 2002; Wenger, McDermott, and Snyder 2002), particularly when these are deployed in target-driven and policy-dependent contexts. These approaches can be seen as an attempt to capitalize on the "organic" intra-organizational learning processes and enhance transitions between individual, group and organizational levels of learning (Berta et al. 2015; Crossan, Lane, and White 1999; Kislov et al. 2014), thus counterbalancing the much-criticized public policy emphasis on short-term gains to the detriment of long-term sustainability (Osborne and Brown 2011). Rather sceptically, this study suggests that the agency of facilitators deploying these learning-oriented techniques in practice can be significantly constrained by the very same macro-level systemic influences that they are expected to mitigate.

The paper is organized as follows. The next section explores extant literature on the evolution of managerial techniques, introduces facilitation as a service improvement approach and outlines the research gaps and questions of the study. The empirical setting and the procedures for data collection and analysis are outlined in the *Case and Method* section. The *Findings* section describes the three micro-level processes underpinning the evolution of facilitation over time. The *Discussion* examines the underlying mechanisms behind the distortion of managerial techniques and reflects on the role of contextual constraints in this process. This is followed by a brief concluding section summarizing the contribution, limitations and implications of the study.

Background

Evolution of managerial techniques

In recent decades, the public sector has experienced an upsurge of managerial strategies, tools and techniques aiming to increase its effectiveness and efficiency (Boaden et al. 2008; Collm and Schedler 2014; Osborne and Brown 2011). These approaches are often viewed as rational, modern and progressive, enhancing the legitimacy of the adopting organization (Lozeau, Langley, and Denis 2002). Whilst managerial techniques are often enthusiastically embraced by managers and practitioners involved in service improvement, there is a growing body of critical research highlighting the difficulties and unintended consequences of their practical application (Bate and Robert 2002; Dixon-Woods, McNicol, and Martin 2012; Kislov, Wilson, and Boaden 2016; McCann et al. 2015; Radnor, Holweg, and Waring 2012).

The fundamental issue is the potential "compatibility gap" between a set of assumptions underlying the design of a managerial intervention, on the one hand,

and the actual cultural, structural and political characteristics of the adopting system, on the other (Lozeau, Langley, and Denis 2002; Teisman 2008). This gap can result in the mismatch between the intended and actual use of managerial techniques which has variously been conceptualized as the lack of innovation fidelity (Lewis and Seibold 1993), misalignment between deliberate and emergent strategies (Omidvar and Kislov 2016) or incompatibility of the newly introduced knowledge with an organization's prior knowledge (Collm and Schedler 2014; Mariano and Casey 2015). According to Lozeau, Langley and Denis (2002), such a mismatch can take several forms:

- *Customization*, which involves both adapting the managerial technique *and* adjusting organizational processes;
- *Loose-coupling*, whereby the technique gets adopted only superficially, in a ritualistic way, with the functioning of the organization remaining largely unaffected;
- *Co-optation*, or *corruption*, whereby the technique becomes captured and distorted to reinforce existing organizational roles and power structures.

Finally, Lozeau and colleagues use the term "transformation" to denote those (supposedly quite rare) cases of handling the compatibility gap where the adopting organization modifies its functioning to fit the assumptions behind the managerial technique and where, as a result, the actual use of an innovation does not significantly differ from its intended use.

Difficulties of translating managerial approaches into the public sector should be analysed in the light of the following three sets of tensions. First, most managerial innovations are likely to have fluid and negotiable boundaries and can be viewed as a combination of a "hard core", which is relatively fixed and stable regardless of the context, and a "soft periphery", related to the multiple ways of local implementation (Denis et al. 2002). The greater the uncertainty about the latter, the more scope there will be for customization, loose-coupling and corruption.

Second, not only is there a mutual influence between the managerial technique and the adopting system (Denis et al. 2002), but also the latter is represented by a number of (often conflicting) professional and managerial groups operating at different levels of the hierarchy. For example, professionals have been shown to actively co-opt managerial approaches and internalize them in their practices, thus reversing managerial control (Kamoche, Kannan, and Siebers 2014). It has also been noted that securing the support of one professional group can lead to the alienation of others (Dixon-Woods, McNicol, and Martin 2012; Powell and Davies 2012).

Finally, organizational implementation of managerial innovation is likely to be shaped by the inconsistent policy context (Currie and Suhomlinova 2006). Many quality improvement techniques display a contradiction between the rhetoric of professional empowerment and the command-and-control procedures for auditing the performance data representing the managerial agenda (Lozeau, Langley, and Denis 2002). Furthermore, managerial techniques can be "distorted" in a top-down way to fit the policy imperatives for centralization and target-driven performance management even prior to the "bottom-up" customization in the process of local implementation (Addicott, McGivern, and Ferlie 2007).

Facilitation of service improvement in the public sector

Broadly defined as "a way of developing processes of learning in group contexts" (Gregory and Romm 2001, p. 453), *facilitation* is often deployed by the public sector organizations to enable the mobilization of (research) knowledge into (professional) practice (Berta et al. 2015; Harvey et al. 2002). Facilitation relies on a designated role ("facilitator") encouraging others to reflect upon their current practices in order to identify gaps in performance, introduce change, enable knowledge sharing and thus improve the outcomes of service provision. It is usually goal-oriented, follows a team-based approach and incorporates aspects of project management, leadership, relationship building and communication (Berta et al. 2015; Dogherty, Harrison, and Graham 2010; Harvey and Kitson 2015). To position the debates around the processes and outcomes of facilitation in the context of the broader literature on the evolution of managerial techniques, it is useful to summarize these debates along the three generic sets of tensions introduced in the previous subsection.

Variability of interpretations

Whilst the role of a facilitator, the involvement of teams, the articulation of performance-oriented goals and the enabling nature of the facilitation process can be viewed as the "core" of facilitation, its "periphery" is relatively wide. Crucially, facilitation is a multifaceted intervention, with facilitators often deploying a variety of other tools and techniques as appropriate in a given context (Dogherty, Harrison, and Graham 2010; Harvey et al. 2002). The facilitator role can be filled by clinical professionals, researchers or managers (Harvey and Kitson 2015). The performance goals of facilitation projects can be specified in a top-down fashion by senior managers, clinicians and researchers external to the practice setting or can be collectively determined by clinical teams themselves (Harvey, Kitson, and Munn 2012). It can be designed as a pre-planned and monitored sequence of stages (Dogherty, Harrison, and Graham 2010) or remain deliberately fluid from the outset, allowing for greater flexibility and emergence (Tierney, Kislov, and Deaton 2014).

Complexity of the adopting system

Premised on a team-based approach, facilitation cannot be adopted individually, mandating a reconfiguration of routines and responsibilities at the individual, team and organizational levels (Kislov et al. 2014). Involvement in facilitated improvement projects may differentially affect various professional groups, increasing workload for some of them (Powell and Davies 2012; Tierney, Kislov, and Deaton 2014). In fragmented contexts, such as the primary-care sector, facilitating improvement across multiple organizations can be more problematic than working with intra-organizational project teams with a history of pre-existing relationships (Kislov, Walshe, and Harvey 2012). Having a facilitated intervention endorsed at a senior level may increase its formal adoption but does not guarantee behavioural change and sustainability of improvement (Tierney, Kislov, and Deaton 2014).

Underlying policy-level contradictions

There is a tension between the formalized, managerialist and goal-oriented aspects of facilitation, which often means aligning improvement work with nationally mandated

policy-driven targets (Tierney, Kislov, and Deaton 2014), and the situated, practice-based and emergent nature of team-level learning processes that are seen as fundamental for achieving sustainable change (Berta et al. 2015). On the one hand, as an approach respecting the collective, situated and practice-based nature of learning, facilitation may well achieve the improvement goals accepted by the adopting system; on the other hand, the externally driven target-oriented culture can adversely affect the horizontal processes of learning and knowledge sharing that facilitation relies upon (Addicott, McGivern, and Ferlie 2006; Currie and Suhomlinova 2006).

Research gaps and questions

We view facilitation as a managerial technique aiming to achieve service improvement goals through capitalizing on the social nature of organic learning processes within and across organizations. Its application is likely to be shaped by the negotiability of its "soft periphery", by the multilevel context of its implementation and by the tensions played out at the policy level. Exploring these issues can be beneficial for two reasons. First, it can further develop theoretical understanding of facilitation as a learning-oriented managerial technique by shifting the focus of inquiry from facilitators' roles, characteristics and practices (Dogherty, Harrison, and Graham 2010; Petrova et al. 2010) towards the influence structural and institutional constraints can exert on the emergent, contestable and often ambiguous process of facilitation, potentially leading to unintended consequences.

In addition, such exploration is beneficial for theorizing the evolution of managerial techniques in general. Whilst different scenarios of handling the "compatibility gap" between managerial interventions and the adopting systems have been described, their analyses predominantly rely on multiple case studies, therefore tending to focus on cross-case variability, underlying contextual differences and the resulting outcomes of the evolution (Addicott, McGivern, and Ferlie 2007; Hotho, Saka-Helmhout, and Becker-Ritterspach 2014; Lozeau, Langley, and Denis 2002). We know less about how the evolution of managerial techniques actually unfolds in practice as organizations and teams are trying to cope with multiple contextual tensions.

We address these gaps by presenting an in-depth qualitative longitudinal case study of a UK-based knowledge mobilization programme relying on facilitation to achieve evidence-informed change in clinical practice across multiple healthcare organizations. By analysing the evolution of the initiative's approach to facilitation over a 5-year period, we address the following research questions. *How does the interpretation and application of facilitation as a managerial technique evolve over time? How is its evolution shaped by multiple contextual tensions?*

Case and method

The case study was conducted in a 5-year collaborative programme ("Programme") involving a university, a National Health Service (NHS) hospital and primary-care organizations aiming to increase the identification of chronic kidney disease (CKD) and improve the management of blood pressure in CKD patients by facilitating the mobilization of existing health research in day-to-day clinical practice. The single case study approach was selected for the following three reasons. First, the Programme granted us wide access for longitudinal data collection, made possible

by the involvement of two of the three co-authors in the earlier stages of its development and/or implementation. Second, the intensity required for in-depth exploration of organizational change over time would make contemporaneous involvement in multiple cases rather problematic (Van de Ven and Huber 1990). Finally, the Programme represented a theoretical case suitable for exploring our research questions as it explicitly relied on facilitation, deployed designated facilitator roles and operated in a complex and fragmented context.

The remit of facilitators included guiding and supporting multi-professional *improvement teams* (comprised of a practice manager, a general practitioner [GP] and a practice nurse) that were created in primary-care organizations ("general practices"), where research evidence on CKD was to be mobilized. Each year, a new group of general practices was recruited, with three phases of the Programme included in the current analysis. Facilitators were supported in their frontline activities by a *programme team* comprised of a university-based social scientist with expertise in service improvement, a hospital-based nephrologist (a medical doctor specializing in treating diseases of the kidneys) and several managers. The changes in the composition of the programme and improvement teams as well as in the facilitator role over the three phases are outlined in Table 1.

A purposive sampling strategy was used, with forty research participants drawn both from the programme team and participating general practices. Forty-five semi-structured interviews (30–95 min in duration) served as the main method of data collection and were conducted (face-to-face or by phone) in three rounds (2010–2011, 2012–2013 and 2013–2014) to enable longitudinal analysis (Table 2). Five of the research participants were interviewed twice due to their involvement in the Programme throughout several phases. Two of the co-authors were members of the programme team in 2009–2012: the second author participated in the implementation of the Programme as a facilitator while the third author contributed to its design as a social scientist. This enabled them to conduct participant observation of meetings and reflect on their first-hand experiences of facilitation in the first half of the Programme's lifetime. Joint involvement of researchers and practitioners in the development, delivery and evaluation of the Programme reflected the Collaboration's commitment to coproduction, reflexivity and organizational learning.

The following steps were taken to ensure the validity of research findings. The study was led by the first author, who was not part of the programme team. The findings of participant observation provided valuable background information and served as a source of triangulation, but interviews remained the main source of data to minimize potential participatory bias. The second author did not participate in conducting research interviews until after his direct involvement in the practical implementation of the Programme had ended.[2] The third author, who played a key role in the design of the initial intervention, was not involved in interviewing at all. Most of the interviews in the second round of data collection were conducted by an external evaluator independent from the Programme team as part of the broader evaluation commissioned by the Collaboration.[3] Interview questions were deliberately open-ended to elicit rich descriptions and avoid imposing the researchers' emerging theoretical assumptions on research participants (see Supplemental File 1).

The interviews were digitally recorded and transcribed verbatim; transcripts were coded and analysed with the aid of NVivo software. The first stage of data analysis was predominantly inductive, involving a series of emergent descriptive codes and

Table 1. The development of the programme over time.

	First phase (2009–2010)	Second phase (2011–2012)	Third phase (2012–2014)
Composition of the programme team delivering the facilitated intervention	Non-clinical facilitators (2) Manager Data analyst Nephrologist Social scientist	Non-clinical facilitator Clinical facilitators (2) Managers (2) Data analyst Nephrologist Social scientist	Non-clinical facilitators (2) Clinical facilitators (3) Managers (3) Data analyst (All staff working part-time)
Number of general practices involved	19	11	19
Financial remuneration to the general practices	All of the participating general practices were remunerated, including securing the protected time for staff to take part in the learning events	All but one of the practices received funding for participating in the project, which, however, was reduced compared to the first phase	None
Representatives of the general practices involved	Improvement teams (a GP, a practice nurse and a practice manager in the majority of practices) driving the project in their practices and involving the rest of the practice staff as appropriate	Improvement teams with variable degrees of involvement for different team members; often one member of a general practice driving the project locally; other practice staff often remaining uninvolved	Practice nurses, with other clinical and non-clinical practice staff usually remaining uninvolved
Tools, techniques and events used by the facilitators	Quality improvement collaborative methodology Plan-Do-Study-Act cycles Context assessment Regular meetings with the improvement teams based in the participating general practices Full-day workshops (3) Project close workshop	Elements of quality improvement collaborative methodology Regular meetings with teams/individuals championing the project in their practices Electronic audit tool Half-day workshops (2) Project close workshop Teleconferences (5)	Electronic audit tool Half-day workshops (2) Individual feedback sessions with practice nurses
The role of the facilitators	Enabling the general practice staff to implement evidence-informed improvement Facilitating teamwork within general practices and knowledge sharing between them Data collection and monitoring project progress	Enabling the general practice staff to implement evidence-informed improvement Supporting the general practices in using the auditing tool Educating the clinical staff about the management of CKD (clinical facilitator) Data collection and monitoring progress (non-clinical facilitator)	Project management, data collection and analysis, reporting the outcome data to the CCGs (non-clinical facilitators) Auditing general practice registers using the electronic tool (clinical facilitators) Educating the clinical staff about the management of CKD (clinical facilitators)

CCGs: Clinical Commissioning Groups; CKD: chronic kidney disease.

Table 2. Research interviews.

	First phase of data collection (2010–2011)	Second phase of data collection (2012–2013)	Third phase of data collection (2013–2014)	Total
Non-clinical facilitators	2	1	2	*5*
Clinical facilitators	–	2	3	*5*
Programme team managers	1	1	2	*4*
General practice managers	5	2	–	*7*
Practice nurses	3	4	–	*7*
GPs	7	5	–	*12*
Hospital consultants	1	–	1	*2*
Healthcare assistants	–	3	–	*3*
Total	*19*	*18*	*8*	*45*

GP: General practitioner.

following a narrative analytical strategy that aimed at the construction of a detailed story from the raw data. The second stage of analysis aggregated previously identified contextual factors (e.g. emphasis on targets, recruitment patterns, funding etc.) with a number of emerging categories informed by the theoretical framework (e.g. "team engagement", "soft periphery", "facilitation" etc.). Matrix analysis (Nadin and Cassell 2004) was deployed to compare and contrast the three phases of the Programme (see Supplemental File 2). Finally, in an iterative process of refining categories, detecting patterns and developing explanations, existing codes and categories were transformed into three main themes (prioritization of [measurable] outcomes over [interactive] process; reduction of [multiprofessional] team engagement; erosion of the designated facilitator role), which reflected the processes involved in the evolution of facilitation.

Findings

Prioritization of outcomes over process

In the first phase, enabling "the jobbing staff" in the general practices to introduce improvement was seen as fundamental to the programme team approach, with facilitators seen as change agents bringing in the improvement agenda and supplying the "external energy" to give it some momentum:

> … You have to have facilitation for effective improvement projects, and the better your facilitators are, the better you'll get on, because change management's really difficult … and you have to bring a little bit of external energy into that. If you left it to normal jobbing staff on their own … they wouldn't do it, would they, because they're too busy doing the job. So I think the facilitation dimension is incredibly important. (R1 – HC1)[4]

Collaborative improvement methodology, including facilitated feedback sessions in individual practices, regular whole-day learning sessions for all participating practices and Plan-Do-Study-Act cycles, and formalized context assessments were used by the facilitators. The emphasis was put on teamwork, concerted change and spreading improvement within the general practices:

> We did the context assessment with them, and then we would then go back in and discuss the results of that context assessment, and the whole practice would be involved in that, so real tangible things that they could then take forward in their practice…. (R1 – M1)

The second phase of the Programme saw an introduction of a clinical audit tool that automated most of the register verification work that had previously been done by the practice staff manually. At the same time, the number and duration of the face-to-face interactive components decreased, virtually disappearing at the third phase of the Programme. The collaborative methodology was also toned down and later completely abandoned, with a growing emphasis on adapting the initial facilitated approach, which was now seen as too "rigid" and "resource-intensive", in order to achieve the measurable outcomes (the number of CKD patients identified and controlled) in a more cost-effective way:

> … In the third phase especially … people were asked to buy-in to an outcome, and so, rightly or wrongly, delivering that outcome becomes a primary focus, however you achieve that. (R3 – M2)

This manifested in increasing emphasis on the use of the electronic audit tool at the expense of creating a team-based shared learning environment for sustaining the improved management of CKD in the longer term:

> … We came a little bit more focused on what' s measureable … more target than behaviour change driven.… (R3 – M3)

> … [The electronic audit tool] became … the main theme of the project really … It completely revolves around [the tool].… (R3 – NCF3)

> … The third phase … was more prescriptive in terms of the steps that people went through; there wasn't that kind of shared learning environment.… (R3 – M2)

Many research participants identified the short-term focus on measurable quick fixes expressed by the NHS in general, and the Clinical Commissioning Groups (CCGs) – groups of general practices whose governing bodies are responsible for commissioning the majority of health services in England – in particular, as the main reason behind this change:

> … All [the CCGs] want is the outcome evaluation … it's very interesting and it's very hard to measure the benefits of that process and the sustainability of what happened. So they're spending their money for an outcome. (R3 – M2)

It was noted that putting an emphasis on measurable outcomes eased the recruitment of practices through the CCGs as it "seemed to open doors more easily, more quickly" (R3 – M3) but, similarly to what Tierney, Kislov and Deaton (2014) observed, did not increase the motivation or enthusiasm of participating general practices. This theme is developed further in the next subsection.

Reduction of multi-professional team engagement

In the first phase, the multi-professional improvement teams, supported by the facilitators, were driving improvement in their practices, aiming to involve all general practice staff:

> We had a training session within the practice meeting, for everybody, as to what we were hoping to achieve at the end.… We also spoke to the staff about why we were doing it and what the benefit would be to the practice, and the patients; and also how they could help.… The practice nurse trained the other practice nurse.… Then of course [the GP involved in the improvement team] trained [the other GP] on how to deal with the blood results that came in … and how to code.… So everybody knew what they were doing.… (R1 – PM1)

Despite difficulties (such as resistance to organizational change expressed by some of the practice staff) that this approach encountered in some practices, most improvement teams managed not only to improve the CKD outcomes but also introduce improvements to other areas of care. Research participants attributed the success of the improvement teams to their enthusiasm (these practices were early adopters who had voluntarily signed up to the Programme) as well as the provision of financial remuneration to the participating practices, allowing them, among other things, to provide protected time to the staff involved in the improvement work:

> … Initially, everybody was saying, " When are we going to have time, how are we going to back-fill some of the sessions taken out?" And once there was a reassurance that there were going to be locums or additional hours covered, everybody was on board with [the CKD project]. (R1 – PM4)

At the second phase, the practices were still strongly encouraged to create improvement teams and involve the rest of their practice staff in improvement work; the most typical scenario now included one or two members of the improvement team heavily involved in the project, with other team members remaining peripheral and the rest of the practice relatively uninvolved:

> My nurses were a bit too busy to get involved with [the project]. So [the healthcare assistant] has got involved. …I think the nurses have missed out really. (R2 – PM6)

> … Phase one: my understanding was that it would be a self-identified multi-disciplinary practice team made-up of an administrator, a general practitioner, and a practice nurse. In the second phase, a lot looser … but there was that kind of: if you can, then a multi-disciplinary team would be great…. (R3 – M2)

In the third phase, departure from the initial model continued, with practice nurses becoming the only professional group involved in running the CKD work:

> … The doctors had no involvement whatsoever; the nurses did everything they could for the project, but really … were battling it out on their own, a lot of them doing any work that was to be done in their lunch hours. (R3 – CF2)

Many respondents believed that the lack of interest from most of the practice staff was related to the lack of protected time (the third phase of the Programme did not provide remuneration to participating practices) as well as the top-down imposition of the CKD project on practices by their CCGs, with staff often being unaware of their organization signing up for it at all until they were contacted by a facilitator:

> The first phase: that was just the recruitment of individual practices where these practices expressed an interest to take part, whereas the further on you moved through the phases it was a CCG decision to take part…. (R3 – M3)

Gradual reduction of general practice engagement from a multi-professional improvement team doing the CKD work together to practice nurses "battling it out on their own" was also accompanied by decreasing involvement of the social scientist and the nephrologist (both strong proponents of "facilitation") and a growing role of management in the second and third phases of the Programme, particularly in relation to controlling the allocation of resources to different activities. Another important change that gradually developed in the programme team over that time involved the gradual transformation of the facilitators' role; this is described in detail below.

Erosion of the designated facilitator role

The first phase of the Programme involved two non-clinical facilitators whose main role was to guide and support improvement teams in their joint improvement work:

> …[The facilitator] visiting regularly … for us it didn't feel like a pressure, it was more of a motivation; it helped us keep our enthusiasm. (R1 – GP2)

> The [facilitators] told us about the way to register these patients correctly, which we wouldn't have done without them telling us, keeping us on our toes really. … Because you knew [the facilitator] was coming in to see you, you had to have that information ready, and you knew that they were going to give you information of the previous few months … so that we knew exactly where we were up to and where we needed to be. (R1 – PN2)

As the non-clinical facilitators were occasionally seen as lacking legitimacy and clinical expertise, starting from the second phase, a clinical facilitator with a nursing background was added to the programme team. Most of the frontline facilitation was delegated to the new recruit, and by the end of the second phase, the non-clinical facilitator's role started to resemble that of a project manager:

> …[The non-clinical facilitator] stepped up then and was doing more of the liaising with stakeholders and recruiting more practices, more office-based. I think he took on more of a management lead … I've kept him in the loop with what's happening at the practices but … he's been pretty hands-off going into the practices. (R2 – CF1)

In the third phase, more part-time clinical facilitators were recruited to the programme team. As a response to the disengagement of the general practices described in the previous subsection, the remit of these facilitators shifted from an initial focus on "enabling others to implement change" to a heavy involvement in the actual process of implementation:

> … A facilitator would be likely to do more, in terms of actually operational stuff that in the past the practice would have done themselves – a lot slower granted, and probably a lot of workarounds et cetera, but actually the practice would've had to do it – whereas in this third phase it felt that it was a little more given to them on a plate in a way. (R3 – M2)

This shift from "facilitating" to "doing" was enabled by the professional knowledge and expertise of the clinical facilitators that the non-clinical facilitators did not possess:

> …[The non-clinical facilitators] can't be tempted into doing certain things for people because they don't know how to do them, and they're not a clinician, or they can't make a decision about a particular patient. And clinicians are by nature, you know, our job is … to help people and fix things … and there is a risk of taking your skills and knowledge and doing things for the teams…. (R3 – HC1)

It was often reported in the third phase that this approach was the only way to achieve the objectives of the Programme in many of the general practices due to multiple constraints, such as the lack of protected time, the absence of clinical champions and a growing emphasis on achieving performance objectives:

> I did so much of the work for them…. I don't think it was a decision so much as the fact that it just wouldn't have been done otherwise. …Most of the objectives were met, but looking at it long-term for changes to the practice … although the project was completed, and the outcomes were very good, because I did so much of the work for them I don't think the changes in the practice will be as sustainable. (R3 – CF2)

As the last quote illustrates, at the end of the third phase, the members of the programme team expressed strong concerns about the sustainability of change in the long term despite the fact that the "official" project performance indicators (such as the number of the CKD patients identified and their blood pressure parameters) were consistently achieved.

Discussion

Evolution of managerial techniques: "soft core" and "hard periphery"?

We have described three interrelated and overlapping practice-level processes that underpin the evolution of facilitation in the contemporary context of the English primary healthcare sector. The first process, *prioritization of outcomes over process*, denotes the gradual loss of interactive elements of facilitation whilst retaining the focus on those activities that provide a quicker and less resource-intensive way to achieve measurable outcomes of improvement. The second process, *reduction of team engagement*, describes a gradual disintegration and disengagement of multi-professional teams whose input is crucial for sustaining improvement within their organizations. The third process, *erosion of the designated facilitator role*, captures a major shift from the "enabling" function, which forms the core of facilitation (Gregory and Romm 2001; Harvey and Kitson 2015; Harvey et al. 2002; Petrova et al. 2010), towards more conventional project management, service improvement or clinical activities.

These findings enhance our understanding of the interplay between the "hard core" and "soft periphery" (Denis et al. 2002) when applied to managerial techniques. Our case study shows that out of the four core elements of facilitation (the facilitator role, involvement of teams, articulation of performance-oriented goals and the enabling nature of the facilitation process), only one (the goals) remained unchanged throughout the Programme, with other elements being fundamentally transformed or even replaced by activities that were initially seen as secondary elements (such as register verification relying on the electronic audit tool). These developments suggest that managerial techniques may have a "softer" core and "harder" periphery compared to product-based innovations described by Denis and colleagues. This potentially puts managerial innovation at a higher risk of corruption due to privileging some core elements at the expense of others *and* replacing these lost core elements with components of the "periphery".

We also contribute to a theoretical understanding of how managerial techniques evolve over time. Whilst Lozeau, Langley and Denis (2002) present customization, loose-coupling, corruption and transformation as distinct scenarios of closing the compatibility gap between the proposed intervention and the real-world context of its implementation, our data indicate that these could be viewed as temporal stages of the broader evolutionary process. In our case study, the facilitated intervention progressed from transformation in the first phase of the Programme through customization and loose-coupling at the second phase (when the initial model started to be adapted but its core components were not yet completely lost) to corruption in the third phase, whereby the distorted facilitation approach failed to modify existing roles and power structures in the general practices and was co-opted for producing outcomes prioritized by the most powerful stakeholders. As highlighted by the second

and third rounds of data collection, the evolution of a managerial technique is a gradual process, which can be hidden behind the rhetoric pertaining to the initial intervention (also see McCann et al. 2015; Waring and Bishop 2010). For instance, the use of terms such as "facilitation", "facilitators" and "improvement teams" lasted well into the corruption stage, when these terms no longer adequately conveyed the essence of the distorted intervention.

Service improvement in a constraining context: adaptation or distortion?

In contrast to an instrumental view of service improvement as an active reconfiguration of contextual processes and structures (Damschroder et al. 2009; Kitson, Harvey, and McCormack 1998), our study demonstrates that formidable contextual influences can significantly distort improvement approaches, activities and techniques. The eroding effect of policy-driven targets on sustainable service improvement is realized through the duality of goals behind the introduction of managerial techniques. On the one hand, proponents recognize the importance of achieving sustainable change through promoting education, collaboration and knowledge sharing (Dixon-Woods, McNicol, and Martin 2012). On the other hand, this aspect usually remains implicit, unarticulated and elusive, with the outcomes of the "sustainability objective" proving difficult to capture in a transparent and tangible way, which leads to the prominence of more quantifiable, target-related improvement goals that are favoured by the current policy context.

The need to adapt interventions to local context is widely acknowledged in the innovation and public sector management literature (Fervers et al. 2006; Kirsh, Lawrence, and Aron 2008; Krein et al. 2010; Mariano and Casey 2015). However, our data show that whilst facilitators, in theory, can rely on a wide range of tools and techniques to enable improvement (Smolović Jones, Grint, and Cammock 2015), in reality, their agency is severely constrained by the context they work in. This can be explained by the facilitators' relative lack of power as well as by the strict compliance of healthcare organizations to the target-focused policy imperatives operating at the institutional level. This significantly limits opportunities for playing on contextual contradictions to circumvent constraints – a strategy often associated with more autonomous and less policy-driven private sector contexts (Hotho, Saka-Helmhout, and Becker-Ritterspach 2014; Levina and Orlikowski 2009). Moreover, the shift from "enabling" towards "doing" and "managing" demonstrates that in constraining contexts, the designated facilitator roles themselves may become distorted, further undermining the interactive, enabling, facilitative aspects of sustainable service improvement (also see Kislov, Hodgson, and Boaden 2016).

It would perhaps be too simplistic to reduce the distortion of managerial techniques to a contradiction between professional and managerial goals (also see Hewison, Gale, and Shapiro 2012). Although the disengagement of multi-professional teams that we observed in the third phase of the Programme can be interpreted as a manifestation of professional resistance, especially if taken out of context, it should be weighed alongside the following. We did not find evidence of resistance among primary-care clinicians in relation to the improvement project goals per se, which were clinical in nature and endorsed by the local actors in a position of professional power. In fact, the resistance of professionals predominantly involved their unwillingness (or, rather, inability) to be actively involved in improvement work unless

supported by the provision of protected time and recruitment of additional clinical members of staff, neither of which is possible without substantial financial investment. In addition, differences in the improvement team dynamic between the first and second phases of the Programme resonate with previous observations that the interest in quality improvement significantly varies between different organizations (Krein et al. 2010), with "early adopters" being more likely to be recruited in the initial phases of new improvement projects (Walshe 2009).

Conclusion

The theoretical contribution of this paper is threefold. First, drawing on the distinction between the "hard core" and "soft periphery" of innovation (Denis et al. 2002), we show that the distortion of managerial techniques involves privileging some core elements at the expense of others and replacing the latter by peripheral components. Second, we suggest that the four types of handling the compatibility gap between a managerial technique and the context of its implementation, namely transformation, customization, loose-coupling and corruption (Lozeau, Langley, and Denis 2002), can represent stages of the same process rather than distinct independent categories. Finally, we demonstrate that the agency of facilitators deploying managerial techniques to enable long-term learning and sustainability is significantly constrained and eroded by the very same macro-level influences they attempt to mitigate, which makes us question previous observations that facilitative approaches shift "away from the primacy of organizational outcomes towards the celebration of the subjectivity of the individual" (Perriton 2007, 169).

Our analysis has important implications for current debates around the development of designated service improvement roles, such as facilitators, in the healthcare context. Non-clinical facilitators working in healthcare, whilst having strong interpersonal skills and/or improvement expertise (Harvey and Kitson 2015), may lack legitimacy, which can be rectified by the deployment of clinicians to fill these designated roles (Petrova et al. 2010; Shipman et al. 2003). Our findings suggest that whilst both groups of facilitators have strengths, the evolution of these roles in practice demonstrates a common tendency to shift away from the interactive, enabling, facilitative aspects of service improvement. This shift, however, takes a different form in each of the two cases. *Non-clinical facilitators* switch from "enabling" (frontline facilitation of service improvement) to "managing" (i.e. office-based project management and performance measurement). *Clinical facilitators*, in turn, demonstrate the shift from "enabling" to "doing" (i.e. involvement in the actual improvement work instead of supporting and educating others), which is made possible by their professional knowledge and skills (Kislov, Hodgson, and Boaden 2016).

This study is not without limitations. First, we did not manage to recruit primary-care-based interviewees (such as practice nurses or practice managers) for the third phase of data collection, limiting analysis to the reflections of the core programme team. This provides additional evidence of the disengagement of multidisciplinary teams as a mechanism underpinning the distortion of facilitation. Second, this study aimed to identify general trends in the evolution of facilitation, and an examination of variability in the responses of individual general practices to an improvement intervention was therefore beyond the scope of this paper. Finally, our conclusions about the impact the evolution of facilitation can have on the local sustainability of

improvement should be treated as untested propositions until corroborated by empirical evidence collected after the end of the intervention.

Our analysis is likely to be applicable to a wide range of theoretically informed managerial techniques and service improvement approaches deployed by public sector organizations, particularly those relying on purposefully created roles to enable long-term learning and sustainability. It highlights the need for facilitators, improvement specialists and other change agents to be conscious of the fine line between the *adaptation* of service improvement approaches advocated in the managerialist literature and their *distortion* with an associated loss of potential to enact and sustain positive change. Finding new ways of achieving context-sensitive customization of improvement techniques without losing their core elements could provide a useful direction for future empirical inquiry. We would particularly encourage an exploration of the following questions. How do successful adopters and implementers of managerial innovation counterbalance the evolutionary processes described in this paper? How can the "core" elements of managerial innovation be "protected" from the eroding effects of public policy short-termism? How can the "enabling" function of learning-oriented managerial techniques be fostered, maintained and developed in the longer term?

Notes

1. Following Boyne (2003), we define public service improvement as "*a closer correspondence between perceptions of actual and desired standards of public services*" (emphasis in original).
2. Research participants taking part in the third round of data collection were aware of the previous involvement of the second author in the implementation of the Programme. We had therefore expected the research participants to demonstrate positive evaluation bias in the third round of interviewing and were surprised by the critical nature of the actual accounts received. This could be explained by the trusting relationship between the second author and research participants enabled by his prolonged engagement of the field as well as by the Collaboration's organizational culture encouraging critical reflexivity.
3. This evaluation focused only on the second phase of the Programme, and its process component was directly relevant to our exploration of facilitation. The inclusion of the evaluation interviews in our study was agreed with the external evaluator.
4. The following abbreviations are used to indicate respondents who are quoted in this section: R1 – first round of data collection; R2 – second round of data collection; R3 – third round of data collection; CF – clinical facilitator; GP – general practitioner; HC – hospital consultant; M – manager (supporting facilitators in the programme team); NCF – non-clinical facilitator; PM – practice manager (based in a primary care organization taking part in the Programme); PN – practice nurse.

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Notes on contributors

Roman Kislov is Research Fellow at Alliance Manchester Business School. His research interests include boundary management, communities of practice, knowledge brokering and utilization of research knowledge in professional practice in the context of collaborative research partnerships. His work has recently appeared in the Journal of Management Inquiry, Implementation Science and Public Administration.

John Humphreys is a project manager in a collaborative partnership between The University of Manchester and Salford Royal NHS Foundation Trust. He is interested in exploring the limits of managerial approaches in actual practice and understanding the barriers to the implementation of complex organizational change in healthcare organizations. He contributes to healthcare quality improvement journals.

Gill Harvey has published widely on service improvement and knowledge mobilization in the public sector. She is currently involved in a number of projects implementing and evaluating knowledge mobilization initiatives in healthcare. A particular interest is in exploring and applying broader organizational and management theories of learning and knowledge management to the study of knowledge translation in healthcare contexts.

ORCID

Roman Kislov http://orcid.org/0000-0003-2525-7673
John Humphreys http://orcid.org/0000-0003-4210-816X
Gill Harvey http://orcid.org/0000-0003-0937-7819

References

Addicott, R., G. McGivern, and E. Ferlie. 2006. "Networks, Organizational Learning and Knowledge Management: NHS Cancer Networks." *Public Money & Management* 26 (2): 87–94. doi:10.1111/j.1467-9302.2006.00506.x.

Addicott, R., G. McGivern, and E. Ferlie. 2007. "The Distortion of a Managerial Technique? The Case of Clinical Networks in UK Health Care." *British Journal of Management* 18 (1): 93–105. doi:10.1111/j.1467-8551.2006.00494.x.

Bate, S. P., and G. Robert. 2002. "Knowledge Management and Communities of Practice in the Private Sector: Lessons for Modernizing the National Health Service in England and Wales." *Public Administration* 80 (4): 643–663. doi:10.1111/1467-9299.00322.

Berta, W., L. Cranley, J. W. Dearing, E. J. Dogherty, J. E. Squires, and C. A. Estabrooks. 2015. "Why (We Think) Facilitation Works: Insights from Organizational Learning Theory." *Implementation Science* 10: 13. doi:10.1186/s13012-015-0323-0.

Boaden, R., G. Harvey, C. Moxham, and N. Proudlove. 2008. *Quality Improvement: Theory and Practice in Healthcare*. Coventry: NHS Institute for Innovation and Improvement.

Boyne, G. A. 2003. "What Is Public Service Improvement?" *Public Administration* 81 (2): 211–227. doi:10.1111/1467-9299.00343.

Collm, A., and K. Schedler. 2014. "Strategies for Introducing Organizational Innovation to Public Service Organizations." *Public Management Review* 16 (1): 140–161. doi:10.1080/14719037.2013.822528.

Crossan, M. M., H. W. Lane, and R. E. White. 1999. "An Organizational Learning Framework: From Intuition to Institution." *Academy of Management Review* 24 (3): 522–537. doi:10.5465/amr.1999.2202135.

Currie, G., and O. Suhomlinova. 2006. "The Impact of Institutional Forces upon Knowledge Sharing in the UK NHS: The Triumph of Professional Power and the Inconsistency of Policy." *Public Administration* 84 (1): 1–30. doi:10.1111/j.0033-3298.2006.00491.x.

Damschroder, L. J., D. C. Aron, R. E. Keith, S. R. Kirsh, J. A. Alexander, and J. C. Lowery. 2009. "Fostering Implementation of Health Services Research Findings into Practice: A Consolidated Framework for Advancing Implementation Science." *Implementation Science* 4: 50. doi:10.1186/1748-5908-4-50.

Denis, J. L., Y. Hebert, A. Langley, D. Lozeau, and L. H. Trottier. 2002. "Explaining Diffusion Patterns for Complex Health Care Innovations." *Health Care Management Review* 27 (3): 60–73. doi:10.1097/00004010-200207000-00007.

Dixon-Woods, M., S. McNicol, and G. Martin. 2012. "Ten Challenges in Improving Quality in Healthcare: Lessons from the Health Foundation's Programme Evaluations and Relevant Literature." *BMJ Quality & Safety* 21 (10): 876–884. doi:10.1136/bmjqs-2011-000760.

Dogherty, E. J., M. B. Harrison, and I. D. Graham. 2010. "Facilitation as a Role and Process in Achieving Evidence-Based Practice in Nursing: A Focused Review of Concept and Meaning." *Worldviews on Evidence-Based Nursing* 7 (2): 76–89. doi:10.1111/j.1741-6787.2010.00186.x.

Downe, J., C. Grace, S. Martin, and S. Nutley. 2010. "Theories of Public Service Improvement." *Public Management Review* 12 (5): 663–678. doi:10.1080/14719031003633201.

Ferguson-Amores, M. C., M. García-Rodríguez, and J. Ruiz-Navarro. 2005. "Strategies of Renewal: The Transition from 'Total Quality Management' to the 'Learning Organization'." *Management Learning* 36 (2): 149–180. doi:10.1177/1350507605052556.

Fervers, B., J. S. Burgers, M. C. Haugh, J. Latreille, N. Mlika-Cabanne, L. Paquet, M. Coulombe, M. Poirier, and B. Burnand. 2006. "Adaptation of Clinical Guidelines: Literature Review and Proposition for a Framework and Procedure." *International Journal for Quality in Health Care* 18 (3): 167–176. doi:10.1093/intqhc/mzi108.

Gregory, W. J., and N. R. A. Romm. 2001. "Critical Facilitation: Learning through Intervention in Group Processes." *Management Learning* 32 (4): 453–467. doi:10.1177/1350507601324003.

Harvey, G., and A. Kitson, eds. 2015. *Implementing Evidence-Based Practice in Healthcare: A Facilitation Guide*. London: Routledge.

Harvey, G., A. Kitson, and Z. Munn. 2012. "Promoting Continence in Nursing Homes in Four European Countries: The Use of PACES as a Mechanism for Improving the Uptake of Evidence-Based Recommendations." *International Journal of Evidence-Based Healthcare* 10 (4): 388–396. doi:10.1111/j.1744-1609.2012.00296.x.

Harvey, G., A. Loftus-Hills, J. Rycroft-Malone, A. Titchen, A. Kitson, B. McCormack, and K. Seers. 2002. "Getting Evidence into Practice: The Role and Function of Facilitation." *Journal of Advanced Nursing* 37 (6): 577–588. doi:10.1046/j.1365-2648.2002.02126.x.

Hewison, A., N. Gale, and J. Shapiro. 2012. "Co-Production in Research: Some Reflections on the Experience of Engaging Practitioners in Health Research." *Public Money & Management* 32 (4): 297–302. doi:10.1080/09540962.2012.691311.

Hotho, J. J., A. Saka-Helmhout, and F. Becker-Ritterspach. 2014. "Bringing Context and Structure Back into Situated Learning." *Management Learning* 45 (1): 57–80. doi:10.1177/1350507612468420.

Kamoche, K., S. Kannan, and L. Q. Siebers. 2014. "Knowledge-Sharing, Control, Compliance and Symbolic Violence." *Organization Studies* 35 (7): 989–1012. doi:10.1177/0170840614525325.

Kirsh, S. R., R. H. Lawrence, and D. C. Aron. 2008. "Tailoring an Intervention to the Context and System Redesign Related to the Intervention: A Case Study of Implementing Shared Medical Appointments for Diabetes." *Implementation Science* 3: 34. doi:10.1186/1748-5908-3-34.

Kislov, R., D. Hodgson, and R. Boaden. 2016. "Professionals as Knowledge Brokers: The Limits of Authority in Healthcare Collaboration." *Public Administration* 94 (2): 472–489. doi:10.1111/padm.12227.

Kislov, R., K. Walshe, and G. Harvey. 2012. "Managing Boundaries in Primary Care Service Improvement: A Developmental Approach to Communities of Practice." *Implementation Science* 7: 97. doi:10.1186/1748-5908-7-97.

Kislov, R., H. Waterman, G. Harvey, and R. Boaden. 2014. "Rethinking Capacity Building for Knowledge Mobilisation: Developing Multilevel Capabilities in Healthcare Organisations." *Implementation Science* 9: 166. doi:10.1186/s13012-014-0166-0.

Kislov, R., P. Wilson, and R. Boaden. 2016. "The 'Dark Side' of Knowledge Brokering." *Journal of Health Services Research & Policy*. published online ahead of print. doi:10.1177/1355819616653981.

Kitson, A., G. Harvey, and B. McCormack. 1998. "Enabling the Implementation of Evidence Based Practice: A Conceptual Framework." *Quality & Safety in Health Care* 7 (3): 149–158. doi:10.1136/qshc.7.3.149.

Krein, S. L., L. J. Damschroder, C. P. Kowalski, J. Forman, T. P. Hofer, and S. Saint. 2010. "The Influence of Organizational Context on Quality Improvement and Patient Safety Efforts in Infection Prevention: A Multi-Center Qualitative Study." *Social Science & Medicine* 71 (9): 1692–1701. doi:10.1016/j.socscimed.2010.07.041.

Levina, N., and W. J. Orlikowski. 2009. "Understanding Shifting Power Relations within and across Organizations: A Critical Genre Analysis." *Academy of Management Journal* 52 (4): 672–703. doi:10.5465/AMJ.2009.43669902.

Lewis, L. K., and D. R. Seibold. 1993. "Innovation Modification During Intraorganizational Adoption." *Academy of Management Review* 18 (2): 322–354. doi:10.5465/amr.1993.3997518.

Lozeau, D., A. Langley, and J. L. Denis. 2002. "The Corruption of Managerial Techniques by Organizations." *Human Relations* 55 (5): 537–564. doi:10.1177/0018726702055005427.

Mariano, S., and A. Casey. 2015. "Is Organizational Innovation Always a Good Thing?" *Management Learning* 46 (5): 530–545. doi:10.1177/1350507615569429.

McCann, L., J. S. Hassard, E. Granter, and P. J. Hyde. 2015. "Casting the Lean Spell: The Promotion, Dilution and Erosion of Lean Management in the NHS." *Human Relations* 68 (10): 1557–1577. doi:10.1177/0018726714561697.

Nadin, S., and C. Cassell. 2004. "Using Data Matrices." In *Essential Guide to Qualitative Methods in Organizational Research*, edited by C. Cassell and G. Symon, 271–287. London: SAGE Publications.

Omidvar, O., and R. Kislov. 2016. "R&D Consortia as Boundary Organisations: Misalignment and Asymmetry of Boundary Management." *International Journal of Innovation Management* 20 (2): 1650030. doi:10.1142/S1363919616500304.

Osborne, S. P., and K. Brown. 2005. *Managing Change and Innovation in Public Service Organizations*. London: Routledge.

Osborne, S. P., and L. Brown. 2011. "Innovation, Public Policy and Public Services Delivery in the UK. the Word that Would Be King?" *Public Administration* 89 (4): 1335–1350. doi:10.1111/j.1467-9299.2011.01932.x.

Perriton, L. 2007. "The Personal Becomes Polemical? The Problematic Second Generation of Facilitative Practice." *Management Learning* 38 (2): 155–171. doi:10.1177/1350507607075773.

Petrova, M., J. Dale, D. Munday, J. Koistinen, S. Agarwal, and R. Lall. 2010. "The Role and Impact of Facilitators in Primary Care: Findings from the Implementation of the Gold Standards Framework for Palliative Care." *Family Practice* 27: 38–47. doi:10.1093/fampra/cmp066.

Powell, A. E., and H. T. O. Davies. 2012. "The Struggle to Improve Patient Care in the Face of Professional Boundaries." *Social Science & Medicine* 75 (5): 807–814. doi:10.1016/j.socscimed.2012.03.049.

Radnor, Z. J., M. Holweg, and J. Waring. 2012. "Lean in Healthcare: The Unfilled Promise?" *Social Science & Medicine* 74 (3): 364–371. doi:10.1016/j.socscimed.2011.02.011.

Shipman, C., J. Addington-Hall, M. Thompson, A. Pearce, S. Barclay, I. Cox, J. Maher, and D. Millar. 2003. "Building Bridges in Palliative Care: Evaluating a GP Facilitator Programme." *Palliative Medicine* 17 (7): 621–627. doi:10.1191/0269216303pm809oa.

Smolović Jones, O., K. Grint, and P. Cammock. 2015. "Public Leadership Development Facilitation and the Crossroads Blues." *Management Learning* 46 (4): 391–411. doi:10.1177/1350507614537020.

Teisman, G. R. 2008. "Complexity and Management of Improvement Programmes." *Public Management Review* 10 (3): 341–359. doi:10.1080/14719030802002584.

Thomas, K., and S. Allen. 2006. "The Learning Organisation: A Meta-Analysis of Themes in Literature." *The Learning Organization* 13 (2): 123–139. doi:10.1108/09696470610645467.

Tierney, S., R. Kislov, and C. Deaton. 2014. "A Qualitative Study of a Primary-Care Based Intervention to Improve the Management of Patients with Heart Failure: The Dynamic Relationship between Facilitation and Context." *BMC Family Practice* 15: 153. doi:10.1186/1471-2296-15-153.

Van de Ven, A. H., and G. P. Huber. 1990. "Longitudinal Field Research Methods for Studying Processes of Organizational Change." *Organization Science* 1 (3): 213–219. doi:10.1287/orsc.1.3.213.

Walshe, K. 2009. "Pseudoinnovation: The Development and Spread of Healthcare Quality Improvement Methodologies." *International Journal for Quality in Health Care* 21 (3): 153–159. doi:10.1093/intqhc/mzp012.

Waring, J. J., and S. Bishop. 2010. "Lean Healthcare: Rhetoric, Ritual and Resistance." *Social Science & Medicine* 71 (7): 1332–1340. doi:10.1016/j.socscimed.2010.06.028.

Wenger, E., R. A. McDermott, and W. Snyder. 2002. *Cultivating Communities of Practice: A Guide to Managing Knowledge*. Boston: Harvard Business Press.